

were less satisfactory. Those cases where ankylosis was threatened the author thinks were benefited by the above treatment. Twelve cases of simple joint exudate remaining after acute articular rheumatism were treated by irrigation (3% carbolic). In these cases the knee was the seat of the disease 13 times, the elbow once, giving a total 14. In nine patients a good result was obtained, and in three almost normal joint motion resulted. The main obstacle in these cases is the periarticular tissue-infiltration which necessitates subsequent massage etc. In purulent exudates after polyarthritis rheumatica (3 cases) the results were favorable, though here we have to contend with a form of joint affection destructive to the cartilages in its tendencies. In none of the cases recorded, however, did the author incise or drain. The results of this mode of treatment were found favorable in synovial suppuration following osteomyelitis of the epiphysis. In syphilitic joint disease the results were encouraging. In 30 cases of tubercular joints the joint-irrigations gave favorable results; improvement in 14 cases. Hueter's injections were used in 14 cases. *Zeitschrift f. Chir.*, Bd. xxvii, heft 1 and 2.

III. Contributions to the Resection and Osteotomy of Ankylosed Joints. By TH. KOLLIKER. (1) In cases of tuberculous coxitis, the author operates with Langenbeck's posterior incision: the trochanter is exposed with the raspatorium and resection knife. The acetabulum should be laid bare and thus any latent processes, osteomyelitis or tuberculosis may be exposed. If tuberculous coxitis exist the cavity of the wound after operation is best filled with iodoform or sublimate gauze. If the diseased process in the bone has long ceased then the continuous suture and drainage are indicated. The after treatment consists in extension for three to six weeks. The patient should carry an extension splint for a year. In bony ankylosis the resection with the chisel is indicated. (Volkmann).

(2) In ankylosis at the knee joint (faulty position) the joint is best exposed by a curved incision beneath the patella. After division of the ligamentum patellæ proprium, a flap including the patella is formed and reflected upward, and the condyles of the femur are sawn through

with a circular saw. The tibia is freshened by superficial section. If the patella can be retained, its surface may be cut and applied to the resected bones. Or, it may be extirpated. The ligamentum patellæ and capsule are sutured with deep, continuous catgut suture. A drain is placed corresponding at each side to the space between the bones, and another through an opening at the extremity of the bursa extensoria. The Esmarch bandage is removed after the extremity is put up in splint.—*Deutsche Zeitschr. f. Chir.* Bd. xxiv, heft 5 and 6.

IV. The Discussion and Therapy of Genu Valgum, and Varum. By Dr. G. MIDDELDORPF (Wurzburg). The author records 30 operations, occurring in the surgical clinic of Prof. Maas. These operations were performed upon 23 patients, ranging from three to twenty years of age. The operations were for the removal of genu valgum (28) and genu varum (2). In 16 cases the deformity was unilateral and six times bilateral. Rachitis was an etiological factor in four cases (3, 5 and 17 years of age respectively). In the rachitic form of the disease, the bloody operation, as a rule, was performed. Genu valgum staticum occurred in 13 patients ages varying from 15 to 22 years. Two cases of congenital patella luxations were aged 26 and 11 years when operated upon. Of the above cases 19 were males. The patients with genu valgum adolescens were bakers (3), locksmiths (3), merchants (2), cabinet makers, type setters, mechanics and servants. Esmarch's bandage was used in most cases. The author notes the use by Maas of the ordinary chisel and wooden mallet in wedge-shaped osteotomy. McEwen's osteotome is used in the linear osteotomy. In double (bilateral) deformity the operation should be performed in one sitting. In operations on the tibia and fibula Maas operates according to Schede with a somewhat modified technique. After making an H or + shaped incision in the periosteum over the tibia he cuts out (chisels) a wedge shaped piece not extending through the whole thickness of the shaft. The base of the wedge varies with the age of the patient and the amount of deformity. The fibula is then chiseled through. The periosteum of the tibia is sewed with catgut, the wound cleaned